Review Article

Geriatric health policy in India: The need for scaling-up implementation

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Abstract

In an anticipation of the rising geriatric population in India, the Central government constituted the National Policy for Older Persons in 1999 to promote the health and welfare of senior citizens in India. A major strategy of this policy is to encourage families to take care of their older family members. The policy also encourages voluntary organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people. The implementation of this policy, particularly in the rural areas, has been negligible and calls for a scaling-up of programs to address the physical, psychological, and social needs of the poor. Due to breakdown of the joint family system and the migration of the younger generation to the towns and cities, the elderly parents in the villages are left to fend for themselves. Too old to work and with little or no source of income, the elders are struggling even to satisfy their basic needs. This article primarily focuses on the various facets of elderly care in India. As a fledgling nation in elderly care, we should take cues from other nations who have pioneered in this field and should constantly evolve to identify and face the various challenges that come up, especially from rural India. The Rural Unit for Health and Social Affairs Department of a well-known Medical College in South India has developed a "senior recreation day care" model which proves to be a useful replicable model to improve the quality of life and nutritional status of the elderly in the lower rungs of society. More than a decade since its inception, it is now the right time to assess the implementation of our geriatric health policy and scale-up programs so that the elderly in our country, irrespective of urban and rural, will have a dignified and good quality life.

Keywords: Geriatric care, gerontology, health policy

Introduction

India is going through a demographic transition with a fall in fertility rate and increase in life expectancy. A positive side of this is rise in working class thereby decrease in dependency ratio. Soon, we will face another challenge with a rapid increase in the number of aged and the associated health and social issues, as large bulk of population will move from working ages to old ages, thereby increasing the old age dependency.[1] Under this context, we should revisit the old age program in India to foretaste our level of preparedness in embracing this challenge.

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Demographic Pattern of Elderly in India

Across the world, the population of the aged is increasing at a rate much higher than (1.9%) the total population growth (1.2%), and is expected to increase further.[2] India's population stands at 1.21 billion as per the 2011 census.[3] In 2008, the geriatric population in India was 90 million which was the second largest in the world, next to China.[4] The population share by the aged increased from 5.3% in 1973 to the current level of 8%, thanks to the progress in the fields of female literacy and public health[5,6] that acted as a leverage in the decline of fertility rate and increase in life expectancy. The proportion remains more or less similar in rural and urban areas with 8.1% and 7.9%, respectively. Among the states, the proportion lies between 7% and 10%, except in Kerala that has the highest proportion

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of elderly (12.6%). One in every eight individual in Kerala is aged over 60 years,[7] a trend that can be attributed to the state's social development. Another noticeable leaning is the growing feminization of aging in India as there are 0.7% more women than men in the elderly age group,[5] primarily because of the differential mortality pattern between men and women.[8] Nearly, two-third of the elderly women are widows whereas only 22% of the elderly men are widowers.[9]

Issues Faced by Elderly

Social

With globalization and economic development, more number of youth are migrating in search of better employment, educational or economic opportunities,[10] leaving elderly behind to fend for themselves. Similarly, the age-old joint family system in India is undergoing various stresses and strains, leading to its gradual disintegration, which will have a greater implication on the life of elderly, given that the joint family has been the essence of social security for elderly care in India since antiquity.[11] Currently, the economic security of elderly is based on self-earning and savings, support from the extended family, primarily children, and support from the state. With the exception of those in the government sector, in India, old age is not synonym with retirement age, a time to enjoy leisure with family and friends. A large proportion of economic security comes from self-earning and savings. Nearly, 90% are dependent on informal sectors such as agriculture, business, and wage work, and only 29% have pension and renting property as a source of income. Those who are drawing pension from organized sector forms a meager 10%. In rural areas, elderly are primarily involved in agriculture and animal husbandry whereas in urban area, they are more drawn in family business and salaried activities. As the age advances, the labor force participation decreases and the dependence on the family and state increases. Gender difference is noticed among the dependents, as more number of women are dependent than men. The old age dependency ratio in India currently stands at 13% and is expected to become 20%.[12] Studies have shown that nearly 58% of the elderly women and 45% of the elderly men are dependent on rural areas, with an average monthly expenditure level between Rs. 420 and Rs. 775, mainly for food, clothing, and health care, whereas in urban areas, it is 64% and 46%, respectively, incurring an average monthly per capita expenditure between Rs. 665 and Rs. 1500. The dependency ratio is found to be high among women and the difference in ratio between men and women is increasing over the years. One of the reasons for this is the large proportion of widows in the elderly age group because of the prevalent practice of men getting married to women of much lower age.[7,9,13] The life expectancy of women is much higher vis-a-vis men. This could also attribute to the high dependency ratio among women. Among men who are economically dependent, more than 90% are living with one or more dependent, whereas only 65% of the elderly women are living with one or more dependent. Abuse among elderly is common when they are economically dependent on the family.[14] The dependence of elderly on family members is based on trust, reciprocity, and helplessness. However, they have been victimized in their own homes. Studies have shown that nearly 25% of the crimes against elderly are committed by their own family members, particularly by sons, daughter-in-laws, neighbors, servant, etc., causes being land and property dispute, caste rivalries, and rural factionalism.[15]

Medical

A familiarity with the medical profile of the elderly is essential for planning and implementation of policy related to healthy old age. Certain diseases are more common among elderly than among the youth. Studies have identified hypertension, cataract, osteoarthritis, chronic obstructive pulmonary disease (COPD), ischemic heart disease, diabetes mellitus, benign prostatic hypertrophy, upper and lower gastrointestinal dysmotility (dyspepsia and constipation), and depression as the common diseases among older patients that account for nearly 85% of all the diagnosis among elderly.[16] Infectious diseases in elderly have a high prevalence of mortality and morbidity.[16] Due to age-related physiological changes and alterations in host defenses, they are more prone to infectious diseases, though the clinical manifestations are subtle and nonspecific. Hypothermia is one of the most common symptoms among elderly than fever. Studies found that fever will be absent in 20–30% of the elderly harboring serious infection. Elderly are vulnerable to acute diseases just like any other age group. However, the probability of manifestation being severe is higher among elderly. Study looking into the cost of acute respiratory infections showed that cost of care was highest among the hospitalized elderly aged 65 years and above than any other age group.[17]

Tuberculosis is emerging as an important disease among elderly, and more than 90% of them are endogenous in origin.[18] One of the biggest problems that are faced by clinicians while tackling tuberculosis in elderly is the inability to get the accurate account of the symptoms. There is a tendency to attribute their symptoms to old age. Abnormal mentation is the most common symptom noticed among elderly than fever, cough, hemoptysis, etc. Tuberculosis-related mortality was 20% among elderly as compared to 3% in younger age group.[19] COPD is one of the most common causes of mortality and morbidity among elderly. Usually, COPD patients have poor health status and quality of life due to the presence of two or more comorbidities and poor activities of daily living (ADL).[20]

Diabetes is becoming an emerging epidemic among the elderly age group.[21] Studies have shown that the age-adjusted rates among elderly are much higher than expected with prevalence ranging between 13% and 16%.[21-23] The prevalence of diabetes increases as the age advances. Sarcopenia, decrease in lean body mass, increase in adiposity, shift of muscle fiber composition to Type 1 which is less glycolytic, decreased physical activity, and obesity, all contributes to insulin resistance and lead to the occurrence of diabetes. Early symptoms of diabetes such as polydipsia and polyphagia are usually absent in elderly patients. The atypical symptoms of diabetes in elderly include confusion,

fall, failure to thrive, neuropathy, coronary artery disease, visual symptoms, and hyperosmolar coma. Apart from the traditionally recognized microvascular and macrovascular complications among elderly, we also need to consider unique complications such as cognitive decline, physical disability, drug-related hypoglycemia, falls, fractures, and geriatric syndrome.[21] Hypertension is one of the most important treatable causes of mortality and morbidity among elderly.[24,25] The prevalence of hypertension among elderly is nearly 40%.[26] It is one of the treatable risk factors of cardiovascular diseases. The prevalence of cardiovascular diseases in the geriatric population is between 13% and 22%.[27] Anemia is another comorbidity that is highly prevalent among elderly. Studies have shown the prevalence to be nearly 40%.[28] Musculoskeletal disorders, especially arthritis, are a major cause of disability and discomfort among elderly. The prevalence of arthritis is quite high with studies showing nearly 60% of the geriatric population being affected by it. They determine the quality of life and the ability to live independently. Their occurrence lead to unstable gait and falls that are the most common causes of elderly morbidity.[16] The other factors that affect the ADL include sensory impairment, primarily visual and hearing impairment.[29] The most common causes for visual impairment among elderly are presbyopia, cataracts, age-related macular degeneration, primary open angle glaucoma, and diabetic retinopathy.[30] As the age advances, the cognitive functions of the elderly also get affected. Depression is quite common among geriatric population. Nearly, 15% of the hospitalized elderly have delirium, usually attributed to the physiological consequences of the medical condition. Disorders such as dementia usually caused by underlying nonreversible conditions such as Alzheimer's and vascular trauma have a huge impact on ADL of the elderly and will increase the burden on caregiver.[16]

Government's Initiative toward Elderly Care

Over the years, government has launched various schemes with the intention of providing health, care, and independence of the elderly around the country. Year 1999 was observed as the International year for older persons by the United Nations general assembly. The same year, the Government of India launched National Policy on Older persons, the primary goal of which was overall well-being of the elderly, ensuring them a legitimate position in the society. It visualizes states in playing an active role in providing financial security, health care, shelter, welfare, and other needs of older persons, such as protection against abuse and exploitation. Following were the highlights of the policy:

- Special focus on elderly women to protect them from being a victim of age, gender, and widowhood
- 60+ as a phase of opportunity, choices, and creativity rather than dependency
- Age-integrated society to strengthen the bond between the young and the old
- Emphasizes the need for expansion of social and community services for older persons, particularly women.

The policy advises strategies such as old age pension, good affordable health services that is very heavily subsidized for the poor through primary health-care system, and the development of health insurance to cater to the needs of different income segments of the population with provision for varying contributions and benefits. It identifies shelter as a basic need and thrust upon welfare measures for elderly who are poor, disabled, the infirm, the chronically sick, and those without family support. It also endorses the role of nongovernmental organizations in elderly care as the state cannot provide all the care needed.[31] Taking cue from the policy, an integrated program for older persons was launched with an objective of improving quality of life of the elderly. It came up with ideas such as respite care homes, multi service centers, and mobile medical care. Unfortunately, a majority of the ideas suggested remained only in paper.[32]

Countries such as Denmark have evolved greatly with respect to the elderly care catering to the health and the social needs. The Danish social service and health-care system is based on free comprehensive medical and social care benefits financed by the government through a relatively high personal tax of 50–70% and a tax on goods and services of 25%. Approximately, 5.6% of Denmark's gross national product is spent on health-care costs. The government assumes welfare of the elderly. The government works through the local leaders who make policies and programs according to the special needs of the community. Series of activities are available through which care will be provided at their doorstep such as senior care centers, social voluntary where elderly help each other, geriatric hospitals, and departments specialized in orthopedic, general internal medicine, terminal care, and dementia.[33]

England is an aging society. It has a well-established health and social welfare policy that responds to problems, recognizing the complex interaction of physical, mental, and social care factors, which can compromise independence and quality of life. Their National Framework for older persons is a comprehensive approach toward elderly care aimed at providing improved quality of care, proper and adequate health-care services, promotion of healthy life styles, independence for those in old age, and prevention of social isolation and social exclusion. The health-care aspects are taken care through the National Health Services, whereas various programs and schemes are put in place, such as the pension scheme, carers' allowance for the caregiver, meals on wheels for people who are unable to cook for themselves, and elderly day care centers to provide their social needs so that geriatric population is well-insulated in all and is not left to fend for themselves.[34]

Cuba is the third world country with a rapidly aging population. With policies such as free health-care system that emphasizes on preventive medicine, Cubans enjoy high life expectancy, with an average life span of 77 years, thus making it one of the oldest in the Americas. Cuba has a sound "cradle to grave" health-care system that is consistently supported by the government,

who made health care an overarching national priority. The constitution considers health care as a right and its delivery is the responsibility of the state, with participation of the population in the development and the maintenance for the system. The fundamental element of Cuban health-care facility is the family physician who provides comprehensive care through the community center. The program for elderly includes continuous follow-up of elderly and once evaluated, they are referred for geriatric consultations to either treat a serious disease or to prevent a complication. Cuba anticipated the increase in geriatric population in the 80s and invested heavily in geriatric programs in which they trained the specialists to oversee the health and welfare of elderly, established national network of social and economic welfare system. They have old people's home for permanent live-in, grandparents' home for day guests, grandparents club for those to prefer to live at home, and eat-in-together for those who are living alone to meet their nutritional needs. Their retirement age is 60 and they are encouraged to remain in force as long as possible. Postretirement, they are encouraged to be involved in social action, education, and transmitting cultural tradition. Special briefing sessions and educational sessions are conducted among the families with an intension to increase respect and consideration for the elderly.[35]

In our institution, Rural Unit for Health and Social Affairs department is running six senior recreation centers with the help of local community and women groups for elderly who belong to the lower rung of the society. These are day care centers that function for 5 days a week where elderly will be involved in activities such as daily devotion, newspaper reading, and games. They will be provided with a wholesome nutritious mid-day meal. Our initial studies have shown that these centers have helped in improving the quality of life and nutritional status of the elderly who are attending it, and the amount spent per person is approximately 1 dollar. This is a very simple and easily replicable model that can be implemented in rural India with the help of community participation.

The Way Forward

Population aging is considered a success of public health policy and socioeconomic development. Now, the time has come to plan a comprehensive public health response catering to the needs and aspirations of the older people.

Planning for elderly: A challenge

Planning a program for elderly is a difficult task, especially in a country like India, primarily due to the intricate fabric of our society, the complex and diverse regional differences, and inter-individual variations. For example, issues such as increase in pension age, elderly who are healthy and strong would want to continue in occupational and social activities, whereas those who are frail would prefer to retire at an early age. Provision for income security and actualization of economic sustainability with adequate room for good health and well-being are some of the formidable challenges faced by policy makers while providing care and support for the geriatric population in India.

Timely implementation and amendment of existing policy

National policy for older persons is definitely a stance taken in the right direction. However, timely implementation of the policy with a provision for evaluation of the process and outcome, thereby making timely amendments at periodic intervals, is equally important for the geriatric population to draw the maximum benefits out of it.

The need for caregiver and elder advocacy in India

India is a developing nation and it still has a long way to go in maternal and child care, nutrition, etc. Our country is yet to be sensitized toward the need for comprehensive geriatric care which otherwise will get absorbed in the myriads of problems our country is facing. Active campaigning and advocacy will be required to promote legislation, influence public policy, conduct research, and provide public education on a wide range of issues of concern to elders and caregivers.

Public–private partnership

Geriatric care cannot be singlehandedly managed by the government and public sector organizations, primarily because of the gargantuan numbers involved, which will only be increasing as the years go by. An amalgamation of ideas and services from public, private, and NGOs are needed for addressing the issue successfully. A separate unit, similar to the Ministry of Women and Child Development, should be set up to look into both the social and health care-related issues of the elderly, giving equal weightage to both.

Intersectoral cooperation

Population aging should not be addressed in isolation. A keen understanding of the societal and familial changes that occur in response to the growing economic and geopolitical changes in the country is essential to provide an effective health, social, and economic support to the elderly. Expertise from various areas such as anthropology, sociology, economics, and health should be brought together to understand the complex and diverse societal changes and political and economic transformations that will help in better planning and implementation of programs.

Program for caregivers

Any program related to elderly should involve and include the family or the caregiver as it still remains as the primary support for elderly in India. Apart from the pension scheme for elderly, specific programs and policies targeting the caregiver should be implemented. Provisions such as providing incentives, formation of support groups, and training classes will be able to provide adequate boost and synergy to those who are primary caregivers. Education of the family and community is indispensable in preventing social isolation of the elderly which will help in their integration into the society, with dignity and respect.

Redefining the roles of center and state

The coverage and utilization of health care in India vary with states which makes the vertical approach in geriatric care less desirable in terms of effective outcome. Each state, in fact, each district should come up with a plan regarding elderly care which is suitable and applicable in their respective areas with center acting as a facilitator and coordinator. There is a huge gap that exists between rural and urban India in terms of knowledge and practice of geriatric care throwing a huge challenge to the administrators and policy makers. Urban India is more aware about the needs of elderly which is corroborated by the sprawling old age homes and special clinics for geriatric population. The needs, attitudes, and economic security in rural India are much different from urban areas. To address the rural needs, we should have programs specifically catering to them involving both men and women, like old age clubs, meant for elderly leisure, organized by the village or by the panchayat and elderly day care centers where they can come and spend time in the morning while other family members go for work. This will be similar to the balwadi or the anganwadi and could be easily run by the government. India being a patriarchal society, unless the program gives special emphasis on women, their needs will be ignored. The bottom-top approach will help us to come up with programs and plans that are applicable and relevant to both urban and rural India. Geriatric hospitals and clinics are the need of the hour for greater focus on the diseases that are more common among the elderly.

Promotion of social science research in geriatric care

Government should encourage social science research in the field of elderly care so that we will be able to come up with programs and policies that will be apt for the Indian scenario. Indian demography is changing; our thinking and research and their manifestations in terms of programs and policies should change along with it.

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Conflicts of interest

There are no conflicts of interest.

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